

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN3315</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/08/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>SODDY-DAISY HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>701 SEQUOYAH ROAD</b> <b>SODDY-DAISY, TN 37379</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 000	Initial Comments  Complaint investigation #30170 was completed at Soddy-Daisy Healthcare Center on August 8, 2012. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

SPBV11

If continuation sheet 1 of 1